Field Key, Evaluation & Management through HCPCS			
Column Title	**Column Description**	**Column Values**	**Value Definitions**
CPT® CODE/ HCPCS CODE	2005 CPT® or HCPCS code		2005 CPT® or HCPCS code
ABBREVIATED DESCRIPTION	Abbreviated CPT® or HCPCS code description.		Abbreviated description for reference purposes only. Refer to a 2005 CPT® or HCPCS code book for complete code description.
DOLLAR VALUE **NON-FACILITY SETTING**	This column indicates the: • Maximum dollar amount for covered services provided in a non-facility setting, or • Pricing method for the procedure code, or • Coverage status for the procedure code.	Dollar Value	Maximum dollar amount payable for covered services.
		AWP	Code priced based on Average Wholesale Price (AWP) or Average Average Wholesale Price (AAWP).
		Bundled	Bundled code, not separately payable.
		By Report	Service paid on a “by report” basis.
		Contracted	Contracted service. Payable only to department’s contracted vendor for State Fund claims. Payable to providers treating Self-Insured injured workers.
		Hosp. Only	Procedure code for hospital outpatient use only.
		Not Covered	Procedure code is not covered.
DOLLAR VALUE **FACILITY SETTING**	This column indicates the: • Maximum dollar amount for covered services provided in a facility setting, or • Pricing method for the procedure code, or • Coverage status for the procedure code.		See “Dollar Value – Non-Facility Setting” above, for column values and definitions.

Field Key, Evaluation & Management through HCPCS (continued)			
Column Title	**Column Description**	**Column Values**	**Value Definitions**
FOL UP	Follow-up Days for Global Surgery	Number	The number of days following surgery during which charges for normal postoperative care are bundled in the global surgery fee.
PRE OP (-56)	Preoperative Percentage (Modifier –56)	Percent	The percent of the total global surgery dollar value that is allowed when modifier –56 is billed.
INTRA OP (-54)	Intraoperative Percentage (Modifier –54)	Percent	The percent of the total global surgery dollar value that is allowed when modifier -54 is billed.
POST OP (-55)	Postoperative Percentage (Modifier –55)	Percent	The percent of the total global surgery dollar value that is allowed when modifier -55 is billed.
PCTC (26/TC)	Professional and Technical Component (Modifiers –26 and –TC) This field identifies whether **professional and technical component modifiers** (-26/-TC) are valid with the procedure code.	0	**Modifiers -26 and -TC are *not valid*.** The procedure is for physician services only; the concept of PC/TC does not apply
		1	**Modifiers -26 and -TC are *valid*.** Diagnostic test or radiology service which has both a professional and technical component.
		2	**Modifiers -26 and -TC are *not valid*.** Stand alone code for the professional component of a diagnostic test. An associated code describes the technical component of the diagnostic test or the global procedure (professional and technical components).
		3	**Modifiers -26 and -TC are *not valid*.** Stand alone code for the technical component of a diagnostic test. An associated code describes the professional component of the diagnostic test or the global procedure (professional and technical components).

Field Key, Evaluation & Management through HCPCS (continued)			
Column Title	**Column Description**	**Column Values**	**Value Definitions**
PCTC (26/TC) **CONTINUED**	Professional and Technical Component (Modifiers –26 and –TC) This field identifies whether **professional and technical component modifiers** (-26/-TC) are valid with the procedure code.	4	**Modifiers -26 and -TC are *not valid*.** Stand alone code for the global procedure for a diagnostic test. Associated codes describe the professional and technical components of the diagnostic test.
		5	**Modifiers -26 and -TC are *not valid*.** Covered service incident to a physician's service when provided by auxiliary personnel employed by and working under the direct supervision of the physician. This service not payable when provided to hospital inpatients or outpatients.
		6	**Modifier -TC is *not valid*; modifier -26 *may be valid*.** Clinical laboratory or other service for which separate payment for interpretations by laboratory physicians or other physicians may be made.
		7	This indicator is not currently in use.
		8	Professional component of a clinical laboratory code; payable *only* if the physician interprets an abnormal smear for a hospital inpatient. **No -TC modifier billing is recognized;** payment for the underlying clinical laboratory test is made to the hospital**.** *Not payable when furnished to hospital outpatients or non-hospital patients.*
		9	**Modifiers -26 and -TC are *not valid*.** Concept of a professional/technical component split does not apply.

Field Key, Evaluation & Management through HCPCS (continued)			
Column Title	**Column Description**	**Column Values**	**Value Definitions**
MSI	Multiple Surgery Indicator (Modifier –51) This field indicates whether multiple surgery payment rules apply to the service.	0	**Modifier -51 is *not valid*.** Payment adjustment rules for multiple surgeries do not apply.
		1	This indicator is not currently in use.
		2	**Modifier -51 is *valid*.** Standard multiple surgery payment policy applies (100%, 50%, 50%, 50%, 50%).
		3	**Modifier -51 *may be valid*.** Multiple endoscopic procedures payment policy applies if this service is billed with another endoscopy in the same family.
		4	This indicator is not currently in use.
		9	**Modifier -51 is *not valid*.** Concept of multiple surgery does not apply.
BSI	Bilateral Surgery Indicator (Modifier –50) This field indicates whether the procedure is subject to a payment adjustment for bilateral surgery.	0	**Modifier -50 is *not valid*.** Payment adjustment rule for bilateral surgery does not apply.
		1	**Modifier -50 is *valid*.** Payment adjustment for bilateral procedures (150%) applies to this procedure.
		2	**Modifier -50 is *not valid*.** Payment adjustment for bilateral procedures does not apply. Procedures in this category include services for which the code descriptor specifically states that the procedure is bilateral; procedures that are usually performed as bilateral procedures; or procedures for which the code descriptor indicates the procedures may be performed either unilaterally or bilaterally.
		3	**Modifier -50 is *not valid*.** Payment adjustment for bilateral procedure does not apply. This is a radiology procedure which is not subject to payment rules for bilateral surgeries.
		9	**Modifier -50 is *not valid*.** Concept of bilateral surgery does not apply.

Field Key, Evaluation & Management through HCPCS (continued)			
Column Title	**Column Description**	**Column Values**	**Value Definitions**
ASI	Assistant Surgeon Indicator (Modifiers –80, -81, -82) This field indicates whether or not an assistant surgeon may be paid for the procedure.	0	**Modifiers -80, -81 and -82 are *not valid under normal situations*.** Assistant at surgery is not usually paid for this procedure. Supporting documentation is necessary to establish medical necessity.
		1	**Modifiers -80, -81 and -82 are *not valid.*** Assistant at surgery may not be paid for this procedure.
		2	**Modifiers -80, -81 and -82 are *valid*.** Assistant at surgery may be paid.
		9	**Modifiers -80, -81 and -82 are *not valid*.** Concept does not apply**.**
CSI	Co-surgeons Indicator (Modifier –62) This field indicates whether or not co-surgeons may be paid for the procedure.	0	**Modifier -62 is *not valid*.** Co-surgeons not permitted.
		1	**Modifier -62 is *not valid under normal situations*.** Supporting documentation is required to establish medical necessity of two surgeons.
		2	**Modifier -62 is *valid*.** Co-surgeons may be paid for this procedure. Supporting documentation is not required if two specialty requirement is met.
		9	**Modifier -62 is *not valid* with this procedure.** Concept of co-surgeons does not apply.
TSI	Team Surgeons Indicator (Modifier -66) This field indicates whether or not team surgeons may be paid for the procedure.	0	**Modifier -66 is *not valid***. Team surgeons not permitted.
		1	**Modifier -66 is *not valid under normal situations*.** Team surgeons may be payable. Supporting documentation is required to establish medical necessity of a team.
		2	**Modifier -66 is *valid.*** Team surgeons permitted.
		9	**Modifier -66 is *not valid*.** Concept of team surgery does not apply.

Field Key, Evaluation & Management through HCPCS (continued)			
Column Title	**Column Description**	**Column Values**	**Value Definitions**
ENDO BASE	Endoscopy Base Code	Code number	This column contains the endoscopic base code for procedure codes that are part of an endoscopy family. The Multiple Surgery Indicator for procedures in an endoscopy family is 3.
FSI	Fee Schedule Indicator This column indicates the payment status for the procedure code.	B	Bundled code, not separately payable.
		C	Contracted service. Payable only to department's contracted vendor for State Fund claims. Payable to providers treating Self-Insured injured workers.
		D	Drug fee based on Average Wholesale Price (AWP) or Average Average Wholesale Price (AAWP).[1]
		F	Flat fee developed by the department
		L	Clinical lab fee
		N	No fee or RVUs available, code paid by report.
		O	For hospital outpatient use only.
		R	RBRVS fee
		T	Tracking code
		X	Non-covered code
LIC REQ	Licensure Required	Y	Appropriate professional licensure is required to bill the department for these codes.
		blank	No special professional licensure is required to bill the department.

(1) Maximum fees effective July 1, 2005 are published in the Average Wholesale Price Fee Schedule. These prices are subject to change. Price updates are available from the Provider Hotline at 1-800-848-0811 and on the Medical Aid Rules and Fee Schedules web site